Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305, titled Medical Dispute Resolution-General, and 133.307, titled Medical Dispute Resolution of a Medical Fee Dispute, a review was conducted by the Medical Review Division regarding a medical fee dispute between the requestor and the respondent named above.

I. DISPUTE

1. a. Whether there should be additional reimbursement of $28,018.15 for dates of service 01/05/02 and extending through 01/10/02.

   b. The request was received on 08/01/02.

II. EXHIBITS

1. Requestor, Exhibit I:

   a. TWCC 60 and Position Statement on Table of Disputed Services
   b. UB-92
   c. TWCC 62 forms
   d. Medical Records
   e. Any additional documentation submitted was considered, but has not been summarized because the documentation would not have affected the decision outcome.

2. Respondent, Exhibit II:

   a. TWCC 60 and Response to a Request for Dispute Resolution
   b. Any additional documentation submitted was considered, but has not been summarized because the documentation would not have affected the decision outcome.

3. Per Rule 133.307 (g) (3), the Division forwarded a copy of the requestor's 14 day response to the insurance carrier on 09/16/02. Per Rule 133.307 (g) (4), the carrier representative signed for the copy on 09/16/02. The response from the insurance carrier was received in the Division on 09/30/02. Based on 133.307 (i) the insurance carrier's response is timely.

4. Notice of Additional Information submitted by Requestor is reflected as Exhibit III of the Commission's case file.

III. PARTIES' POSITIONS

1. Requestor: Table of Disputed Services

   "Claim should be paid at 75% of bill [sic] charges, without any provision for carve-out of implants."

2. Respondent: Letter dated 09/27/02:

"This dispute involves the Carrier's reduction in payment based on a per diem methodology versus stop-loss…. The requestor billed the carrier $66208.45 for this 5-day stay….'To be eligible for stop-loss payment the total audited charges for a hospital admission must exceed $40,000….' Following the carrier's audit, the hospital bill amount was below $40,000. Therefore, the carrier reimbursed the requestor the $5590.00, based on a per diem rate of $1118.00 per day in addition to reimbursement in the amount of plus [sic] 6704.19 for implants at cost plus 10%. The carrier allowed reimbursement for Bak cages, screws, rods and connector clamps. Because the requestor failed to provide invoices for implants, the carrier based the cost of implants on its own data collected for similar services. The total initial payment was $12,294.19. Subsequently, the requestor provided invoice information for implants and the carrier reimbursed the requestor an additional $9344.00, bringing the total payment to $21,638.19…. Payment to the requestor based on stop-loss methodology when the stop-loss threshold was bridged because of an unsubstantiated markup increase in surgical implants, for unknown reasons, is not fair to the carrier or the policy-holder, is not reasonable, and is inconsistent with effective medical cost control."

IV. FINDINGS

1. Based on Commission Rule 133.307(d) (1) (2), the only dates of service (dos) eligible for review are those commencing on 01/05/02 and extending through 01/10/02.

2. The Provider billed the Carrier $66,208.45 for the dos in dispute.

3. The Carrier made a total reimbursement of $21,638.19 for dos in dispute.

4. The amount left in dispute is $28,018.15, per the table of disputed services.

5. The carrier denied the charges as, "DIEM-F—REIMBURSED IN ACCORDANCE WITH THE TEXAS HOSPITAL INPATIENT FEE GUIDELINE; COST- M- N-SERVICES WERE REIMBURSED IN ACCORDANCE WITH THE CARRIER'S FAIR AND REASONABLE, COST DATA IS UNAVAILABLE FOR YOUR FACILITY AT THIS TIME. ADDITIONAL REIMBURSEMENT MAY BE CONSIDERED UPON RECEIPT OF THIS INFORMATION; AND M-THE REIMBURSEMENT FOR THE SERVICE RENDERED HAS BEEN DETERMINED TO BE FAIR AND REASONABLE BASED ON BILLING AND PAYMENT RESEARCH AND IS IN ACCORDANCE WITH LABOR CODE 413.011(B)."

V. RATIONALE

Medical Review Division's rationale:

The medical reports indicate that the services were performed. The medical documentation submitted by the Requestor indicates that the total hospital bill was $66,208.45. Per Rule 134.401 (c)(6)(A)(i)(iii), once the audited bill has reached the minimum Stop-Loss threshold of

$40,000.00, the entire admission will be paid using the Stop-Loss Reimbursement Factor (SLRF) of 75%. Per Rule 134.401 (c)(6)(A)(v), the charges that **may** (emphasis added) be deducted from the total bill are those for personal items (television, telephone); those not related to the compensable injury; or if an onsite audit is performed, those charges not documented as rendered during the admission.

The carrier is allowed to audit the hospital bill on a per line basis. In reading Rule 134.401 (c)(4), additional reimbursement (for implantables or orthotics/prosthetics) **only** (emphasis added) applies if the bill does not reach the stop-loss threshold. The hospital is required to bill, "…usual and customary charges…" per Rule 134.401 (b)(2)(A). The carrier should audit the entire bill to see if the charges represent "usual and customary" amounts. This would include the cost of the implantables. Therefore, the carrier would audit the **implantables** and reduce them to "usual and customary" charges if they thought the bill for the implantables was inflated. (It would not be appropriate to start out the audit by automatically reducing the cost of the implantables to cost + 10%, since the rule states this method is used only for the per diem reimbursement methodology.) The carrier indicated that after their audit, the bill was below $40,000.00. The implantables were paid on an estimated amount based on data collected for similar services because there was no invoice submitted, along with the per diem amount for a surgical admission. An additional amount was paid upon receipt of the invoice for the implantables. There was no documentation submitted by the carrier to indicate that the reduction of the implantables was based on anything more than reducing them up front to cost + 10%. There is no documentation to indicate that the carrier attempted to determine the usual and customary charges billed by other facilities for implantables in the same geographical region as the provider. Even if the charge appears to be inflated based on an invoice or based on information from the fee guidelines, the carrier must determine what is usual and customary for those items in that region and billed by other facilities. If other facilities only bill cost + 10% for implantables, some evidence of that determination would be needed if the facility challenges the reimbursement amount. The carrier would also subtract any personal items or items not related to the compensable injury and then determine the final amount to see if the bill would be paid at the per diem methodology or the stop-loss methodology. There was no copy of the actual audit provided by the carrier in order to determine what had been subtracted from the bill based on Rule 134.401 (c) (6) (v).

Since the carrier has not submitted sufficient information to determine whether or not the hospital should have been paid at per diem or per the stop-loss methodology, the denial code of "M" for the implantables is a moot point. The reimbursement of the implantables at cost plus 10% would only be applicable if the per diem rate was the appropriate reimbursement method. The carrier has not supported their contention that the provider should be paid based on the per diem rate.

Therefore, the Medical Review Division, based on the available documentation, recommends payment in the amount of **$28,018.15.**

VI. ORDER

The above Findings and Decision are hereby issued this 04th day of April 2003.

Carolyn Ollar
Medical Dispute Resolution Officer
Medical Review Division

CO/co

Pursuant to Sections 402.042, 413.016, 413.031, and 413.019 the Medical Review Division hereby Orders the Respondent to remit $28,018.15 plus all accrued interest due at the time of payment to the Requestor within 20 days receipt of this Order.

Judy Bruce
Director of Medical Review
Medical Dispute Resolution

JB/co